



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Trenton D. Weeks, D.C.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-1836-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

March 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This report and bill was performed according to TDWC rules and should be paid in full."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. A designated doctor on 10/23/14 found the claimant to be at maximum medical improvement and assigned an impairment rating... This was the claimant's first evaluation of maximum medical improvement and impairment rating.

2. The requestor, selected by the treating doctor, on 12/18/14 determined the claimant had not reached MMI...

3. Section 408.0041(f2) of the Labor Code states, 'An employee required to be examined by a designated doctor may request a medical examination to determine maximum medical improvement and the employee's impairment rating from the treating doctor or from another doctor to whom the employee is referred by the treating doctor if: (1) the designated doctor's opinion is the employee's first evaluation of maximum medical improvement and impairment rating; and (2) the employee is not satisfied with the designated doctor's opinion.'

4. The requestor, selected by the treating doctor, on 3/12/15 determined the claimant still had not reached MMI...

The Labor Code states the employee may 'request.' It does not state 'requests.' The claimant requested and the treating doctor responded to that request and selected the requestor who evaluated the claimant on 12/18/14. There are no further requests."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 12, 2015, Referral Doctor Examination to Determine Maximum Medical Improvement and Impairment Rating, \$350.00, \$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.0041 sets out the procedures for designated doctor examinations.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-P12 – Workers' compensation jurisdictional schedule adjustment.
 - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

Is the requestor entitled to reimbursement for the disputed service?

Findings

Texas Labor Code §408.0041(h) states that:

The insurance carrier shall pay for:

- (1) an examination required under Subsection (a), (f), or (f-2), unless otherwise prohibited by this subtitle or by an order or rule of the commissioner

Review of the submitted documentation finds that the examination in question was not required under Subsection (a), (f), or (f-2). The requestor has failed to support that they are entitled to reimbursement for the disputed service. No reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	April 14, 2016 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.